

**ADVANTAGE VISION CARE**

UNDERWRITTEN BY FIDELITY SECURITY LIFE INSURANCE COMPANY

GROUP VISION CARE PLAN EMPLOYEE ENROLLMENT/CHANGE FORM

(PLEASE PRINT LEGIBLY)

CHANGE ☐ADD ☐TERMINATION ☐

Effective Date: ____ / ____ / ____

Group Number: **10790-2016**Plan Number: **943**

Sub/Group: _____

Employer Group: **Maricopa County - Voluntary Plan**

Date of Employment: ____ / ____ / ____

Plan Effective Date: ____ / ____ / ____

Employee Name: _____
LAST FIRST M.I.

Date of Birth: ____ / ____ / ____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____

MALE ☐FEMALE ☐

Employee ID Number: _____

Alternative ID Number: _____

Do you wish to cover your eligible Dependents? Yes ☐ No ☐Cancel Coverage ☐

If yes, complete the following:

Name	Last	First	M.I.	Birth Date
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Name	Last	First	M.I.	Birth Date
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Spouse: _____

Child: _____

Child: _____

Child: _____

Child: _____

Child: _____

Once your plans go into effect, you must have a "Qualified Status Change" as defined by the IRC Section 125 in order to modify your Medical, Dental or Spending Account plan elections. Information about the IRC section 125 plans can be found online at <http://www.maricopa.gov/benefits>. It is the **responsibility** of the employee to submit the change request to the Benefits Office, by submitting an enrollment/ change form and attaching appropriate 3rd party documentation of the qualifying event within 31 calendar days of a status change. Retroactive changes will not be allowed unless otherwise required by law.

I authorize payroll deductions(from my paycheck) for the required premiums due for benefits I have chosen. I understand that these rates may be revised periodically. I certify that I have read and agree to abide by the information above.

By submitting my open enrollment request or continuing with my current health care coverage, I understand and agree that Maricopa County may share protected health information (PHI) concerning me and my dependents as described in the Maricopa County Notice of Privacy Practices, with my health care providers, which could include, CIGNA, HealthSelect, Walgreens Health Initiatives (WHI), United Behavioral Health (UBH), United Concordia, Employers Dental Service (EDS), UnumProvident, AVESIS, Application Software Inc, (the flexible spending account administrator) and WHI in its role as Pharmacy Benefits Manager. I further agree to release Maricopa County and Maricopa County's health care providers from any liability for any good faith release of PHI in connection with my benefits or as otherwise authorized or required by law.

Employee's Signature: _____**Date:** _____**FOR OFFICE USE ONLY**☐ **HRMS (001)**☐ **STAR (002)**☐ **Non-Payroll (NP003)**

Effective Date of Coverage: _____

Validation: _____